

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003147

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 316 Primary Registration District No. — Registrar's No. 4

FILED JAN 8 1963

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Francois | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Francois | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp. Farmington, Mo-rural | | c. CITY OR TOWN 418 S. Henry St. | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hwy. "W" | | d. STREET ADDRESS (If outside, give location) Farmington, Mo | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|--|----------------------------------|---|--|-------------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First James Middle Clarence Last Smith | | | 4. DATE OF DEATH Month Jan Day 2 Year 1963 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Sept 16, 1938 | 9. AGE (last birthday) 24 | IF UNDER 1 YEAR Months 24 Days — Hours — Min. — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY Laborer | | |
| 11. BIRTHPLACE (City and state or country) Jackson, Missouri. | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Everett Smith. | | | 13b. MOTHER'S MAIDEN NAME Alta Tongay. | | |
| 14. NAME OF HUSBAND OR WIFE Patty Smith. | | | Address | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) Yes | | | 16. SOCIAL SECURITY NO. 36 | | |
| 17. INFORMANT Mrs. Alta Smith Esther, Mo | | | Address | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Internal Injuries | | INTERVAL BETWEEN ONSET AND DEATH D.O.A. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c) — | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

| | | | |
|---|--|--|---|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Automobile accident | |
| 20c. TIME OF INJURY Hour 3:30 a.m. — p.m. — Month, Day, Year JAN 2 1963 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway | | 20f. CITY, TOWN, OR LOCATION St. Francois COUNTY Mo. STATE Mo. | |
| 21. I attended the deceased from 3:30 p.m. to — and last saw her alive on — Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Ted Boyer, Coroner | | 22b. ADDRESS Bonnetene, Mo | 22c. DATE SIGNED 1-5-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-5-1963 | 23c. NAME OF CEMETERY, OR CREMATORY Woodlawn Cem. | 23d. LOCATION (City, town, or county) Esther, Mo. (State) |
| 24. FUNERAL DIRECTOR Caldwell's Funeral Home Flat River, Mo | | 25. DATE RECD. BY LOCAL REG. Jan 5, 1963 | |
| | | 26. REGISTRAR'S SIGNATURE Esther Rudloff | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/5910940
20945

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JAN 14 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Donald Dale Caldwell

Licensed Embalmer No.

5095

P. O. Address

Flat River, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.